OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

June 23, 2008

Phil Anderson
Director of Regulatory Affairs
Oxford Health Plan
48 Monroe Turnpike
Trumbull, CT 06611

Re: **Guidance on Affordability Plan.**

Dear Mr. Anderson:

As previously committed to UnitedHealthcare of New England and UnitedHealthcare Insurance Company, (hereinafter "United"), this letter gives guidance to United on revisions to the Affordability Plan it submitted as part of it May 15 large group trend factor filing.

This guidance is drawn primarily for Regulation 2 of the Office, particularly Sections 8 and 9. In Section 8, the Commissioner, in the course of carrying out the Office's authority, is directed to take into account efforts by health insurers in Rhode Island to:

(i) develop benefit design and payment policies that:
(A) enhance the affordability of their products, as described in section 9 of the regulation;
(B) encourage more efficient use of the state's existing health care resources;
(C) promote appropriate and cost effective acquisition of new health care technology and expansion of the existing health care infrastructure;
(D) advance the development and use of high quality health care services (e.g., centers of excellence); and
(E) prioritize the use of limited resources.

(ii) promote the dissemination of information, increase consumer access to health care information, and encourage public policy dialog about increasing health care costs and solutions by:
(A) providing consumers timely and user-friendly access to health care information related to the quality and cost of providers and health care services so that consumers can make well informed-decisions;

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(B) encouraging public understanding, participation and dialog with respect to the rising costs of health care services, technologies, and pharmaceuticals; the role played by health insurance as both a financing mechanism for health care and as a hedge against financial risk for the consumers of health care; and potential solutions to the problems inherent in the health insurance market (e.g., market concentration, increasing costs, the growing population of uninsureds, market-driven changes to insurance products (such as the growth of high deductible plans) and segmentation of the insurance market due to state and federal laws); and

(C) providing consumers timely and user friendly access to administrative information, including information related to benefits; eligibility; claim processing and payment; financial responsibility, including deductible, coinsurance and copayment information; and complaint and appeal procedures;

(iii) promote collaboration among the state's health insurers to promote standardization of administrative practices and policy priorities, including

(A) participation in administrative standardization activities to increase efficiency and simplify practices; and

(B) efforts to develop standardized measurement and provider payment processes to promote the goals set out in this regulation;

(iv) direct resources, including financial contributions, toward system-wide improvements in the state's health care system related to quality, access and efficiency, including providing support to local collaboratives, organizations and initiatives that promote quality, access and efficiency;

(v) participate in the development and implementation of public policy issues related to health, including

(A) collaborating with state and local health planning officials;

(B) participating in the legislative and regulatory processes; and

(C) engaging the public in policy debates and discussions.

In Section 9 the following strategies by a health insurer to enhance the affordability of its products are enumerated for the Commissioner's review and assessment:

(i) Whether the health insurer offers a spectrum of product choices to meet consumer needs;

(ii) Whether the health insurer offers products that address the underlying cost of health care by creating appropriate incentives for consumers, employers, providers and the insurer itself. Such incentives will drive efficiency in the following areas:

(A) Creating a focus on primary care, prevention and wellness;

(B) Establishing active management procedures for the chronically ill population;
(C) Encouraging use of the least cost, most appropriate settings and
(D) Promoting use of evidence based, quality care;

(iii) Whether the insurer employs provider payment strategies to enhance cost effective utilization of appropriate services;
(iv) Whether the insurer supports product offerings with simple and cost effective administrative processes for providers and consumers;
(v) Whether the insurer addresses consumer need for cost information through
(A) Increasing the availability of provider cost information; and
(B) Promoting public conversation on trade-offs and cost effects of medical choices; and
(vi) Whether the insurer allows for an appropriate contribution to surplus.

As envisioned by the Office, an annual Affordability Plan for each Rhode Island Health Insurer documents its efforts in the Rhode Island market to comply with these standards. This Affordability Plan does not have a template or required set of components, but should:

- Address activities by the insurer in Rhode Island in the past year in the areas listed above - particularly those in section 9, which could serve as an effective means of categorization and organization.
- Assess the efficacy of those efforts with objective measurements.
- Indicate plans for changes or new initiatives in the coming year, based on those assessments, with anticipated impact.

While some of the tactics employed by insurers may be proprietary – such as a particular provider incentive program – the Office believes that affordability goals and strategies (e.g. improving chronic care treatment through a patient-centered medical home) may in fact be public and collective, and thus common among insurers. Already in RI there is much common work done in Health Information Technology Development and Primary Care Infrastructure improvement. Documenting affordability efforts should further align this work.

It is our expectation that these plans will be filed annually, as part of the large group rate factor filing process. Initially we will honor a request of submitting plans to keep certain proprietary information confidential, however, it is expected that, over time, more of this information will be made public.

As indicated in a separate letter confirming large group rate factors components, United has 30 days from the date of this letter to submit a revised affordability plan.

If you have any questions, please feel free to call me.

Very truly yours,

Christopher F. Koller
Health Insurance Commissioner

cc: Stephen Farrell

UnitedHealthcare of New England and UnitedHealthcare Insurance Company

Large Group Rate/Trend Filing Template

1. Historical Information

Experience Period for Developing Rates

From	To
1Q 2006	4Q 2007

Utilization Data by Quarter (Last 8 available quarters)

Quarter	End Date	IP Days*	OP Net PMPM	M/S Net PMPM	Rx Net PMPM
1	12/31/2007	279.6	$ 89.54	$ 60.04	$ 39.28
2	9/30/2007	307.7	$ 85.29	$ 59.83	$ 37.33
3	6/30/2007	268.7	$ 81.87	$ 62.51	$ 38.26
4	3/31/2007	251.7	$ 74.51	$ 59.71	$ 32.40
5	12/31/2006	213.7	$ 78.01	$ 59.84	$ 33.35
6	9/30/2006	257.1	$ 76.39	$ 58.82	$ 31.54
7	6/30/2006	230.8	$ 75.69	$ 62.50	$ 30.77
8	3/31/2006	266.7	$ 70.16	$ 61.56	$ 30.26

*Days per 1000 members.

Note: We do not believe historical trends based on pmpm average values are meaningful. However, we have provided these averages as requested except for pharmacy .The variation in copays and the distribtuion of members by design from one year to another totally distorts the actual trend. The pharmacy data represents the most popular plan design 10/30/50 (56% of 2007 members).

2. Trend Factors for Projection Purposes (2008 Annualized)

	IP	OP	M/S	Rx	Total Medical
Total	12.0%	9.3%	7.9%	12.5%	9.6%

[redacted]

*All elements should add or compound to the total. If anything is to be reported as "Other" please provide a description.

Note: Historical utilization trends are adjusted to remove demographics, therefore, it is necessary to delineate separately.

3. These trends are intended to be effective with October 2008 renewals. Since rates are impacted by both the change in census and specific experience of a group it is difficult to estimate an average increase. The targeted loss ratio is 83.8% and the risk/profit margin is expected to be 1% for UHNE. The targeted loss ratio is 83.1% and the risk/profit margin is expected to be 1% UHIC. The administrative expense component is 12%.

4. The premium is based on the final renewal premium summed for each group for the period being reported and claims include – paid claims for the incurred period with claim reserves (IBNR), capitation payments for capitated arrangements, and other cost associated with affiliated agreements i.e. OPTIUM SERVICES